ADDENDUM

Chapter 2: Learning About Policy and Environmental Change

chapter 2

ADDENDUM 1

Working on Stroke Legislation

This chapter supplement addresses how a bill becomes law and describes how pending federal legislation on stroke could affect state legislation and the state legislative process in regard to stroke-specific bills. Chapter 2 of the *Communication Guide* offers a discussion of the differences between advocacy and lobbying and offers some guidelines about how state staff can work with legislatures. Generally, state programs can provide information to the legislative branch to foster implementation of public health interventions but cannot work to influence a specific piece of legislation. The information in this section complies with Regulation AR-12, which prohibits using federal funds for lobbying activities.

THIS SECTION PROVIDES

- A step-by-step look at how a federal bill becomes law;
- An overview and legislative history of the federal STOP Stroke bill;
- A mock timeline for stroke legislation with suggestions for how state staff can participate at different milestones;
- Case studies of two states' implementation of stroke legislation or regulations; and
- Resources on state stroke legislation.

REVIEW OF THE FEDERAL LEGISLATIVE PROCESS: HOW A BILL BECOMES LAW

1 Bill is introduced. A bill designated "H.R." is in the House of Representatives. A bill designated "S" is in the Senate.

2 Bill is referred to a specific committee(s) with jurisdiction over the proposed legislation. The bill may then be assigned to a more specialized subcommittee. Most deliberation is done by subcommittees.

3 Committee (or subcommittee) may hold hearings on the bill; this allows various groups to put their views on record.

4 A mark-up session occurs when hearings are completed. Legislators meet to debate and vote on amendments and thus "mark" the bill. If this occurs in a subcommittee, there is then a vote on whether to refer the bill to the full committee. The committee votes on whether to recommend the bill to the House or Senate.

5 If bill is recommended by a committee, it goes before the Senate or House for a vote. There may be debate and amendments. Bill is approved or defeated. If approved by House or Senate, it then goes to the other legislative chamber where the process begins again.

6 If both chambers pass the bill, there may be differences between the two versions. A conference committee made up of Representatives and Senators from both parties is then convened. This group works out the differences between the two bills. Once consensus is reached, the bill goes back to both chambers for a final vote.

7 If both chambers pass an agreed-upon version of the bill, it then goes to the White House for the President's signature. The President may sign or veto the bill. If it is vetoed, the bill goes back to both chambers. A veto may be overridden by a two-thirds vote of the legislative chamber. Both chambers must pass the bill with a two-thirds vote for the bill to become law.

8 If the President does not sign a bill within 10 working days and Congress *is* in session, the bill automatically becomes law.

9 If the President does not sign a bill within 10 working days and Congress *is not* in session, the bill is subject to a "pocket veto" and dies.

OVERVIEW OF THE FEDERAL STROKE TREATMENT AND ONGOING PREVENTION ACT (STOP STROKE ACT)

The STOP Stroke Act was introduced in the U.S. Senate in late 2001. Though it had many cosponsors, the bill did not pass the 107th Congress and was reintroduced during the 108th Congress. A revised version of the bill had passed the House of Representatives but was not expected to pass the Senate in 2004. It is unclear whether it might be reintroduced in the 109th Congress.

In its current draft, the STOP Stroke Act would have

- Amended the Public Health Service Act to authorize the Secretary of the Department of Health and Human Services (HHS) to engage in activities designed to increase knowledge and awareness of stroke prevention and treatment.
- Required the HHS Secretary to conduct educational campaigns, maintain a national registry, and establish an information clearinghouse for the disease. The legislation would authorize $5 million per year for fiscal years 2005 through 2009 for these activities.
- Authorized the HHS Secretary to make grants to states and other public and private entities to develop medical professional training programs and telehealth networks that would seek to coordinate stroke care and improve patient outcomes. The bill would authorize $14 million in 2005 and $70 million for 2005 through 2009 for the programs and for a study to evaluate the telehealth grant program.

The STOP Stroke Act would have required states to use the grants to

1. Identify entities with expertise in the delivery of high-quality stroke treatment;
2. Work with those entities to establish or improve telehealth networks to provide stroke treatment assistance and resources;
3. Inform emergency medical systems of the location of entities to facilitate the transport of individuals with stroke symptoms;
4. Establish networks to coordinate collaborative activities for stroke treatment;
5. Improve access to high-quality stroke care, especially for populations with a shortage of stroke care specialists or with a high incidence of stroke; and
6. Conduct performance and quality evaluations to identify activities that improve clinical outcomes for stroke patients.

States would have also been required to establish a consortium of public and private entities, including universities and academic medical centers, to carry out these activities. The bill prohibits a grant to a state or a consortium within a state with an existing telehealth network for improving stroke treatment unless the state or consortium agrees to use the existing telehealth network to achieve the purpose of the grant. The bill gives priority to any applicant that submits a plan demonstrating how the applicant will use the grant to improve access to high-quality stroke care for target populations.

TIMELINE OF THE STOP STROKE ACT 107th & 108th Congresses of the United States	
DATE	**MILESTONE**
July 31, 2001	S. 1274 introduced by Senators Edward Kennedy and Bill Frist
December 6, 2001	H.R. 3431 introduced by Reps. Lois Capps and Charles "Chip" Pickering, with 68 original cosponsors
February 6, 2002	S. 1274 passed by Senate and referred to the House Energy and Commerce Committee
March 5, 2002	S. 1274 referred to the House Energy and Commerce Subcommittee on Health
April 30, 2002	American Heart Association's annual lobby day on Capitol Hill yielded 30 additional cosponsors for STOP Stroke Act
June 6, 2002	House Energy and Commerce Subcommittee on Health held hearing, "The NIH: Investing in Research to Prevent Disease," to address S. 1274 and H.R. 3431
September 2002	Grassroots letter-writing campaign organized by STOP Stroke Coalition* to put House version of the Act to vote
October 2002	Adjournment of 107th Congress—House did not vote on STOP Stroke Act before adjournment (213 cosponsors)
November 20, 2003	Reintroduction of legislation in the Senate by Senators Thad Cochran and Edward Kennedy (S. 1909)
December 8, 2003	Reintroduction of legislation in the House of Representatives, as H.R. 3658, by Reps. Lois Capps and Charles "Chip" Pickering—Referred to the House Committee on Energy and Commerce
December 17, 2003	Referred to the Subcommittee on Health
January 28, 2003	Considered by Subcommittee, mark-up session and forwarded to Full Committee
March 3, 2004	Considered by Committee, mark-up session and voted to Whole House
March 30, 2004	Reported to whole House of Representatives for vote, placed on the calendar
June 14, 2004	H.R. 3658 passed by the House of Representatives (unanimous consent)
June 15, 2004	Received in Senate as S. 1909; referred to Committee on Health, Education, Labor and Pensions (HELP)—currently in Committee

* STOP Stroke Coalition (American College of Radiology, American Academy of Neurological Surgeons, American College of Preventive Medicine, American Academy of Neurology, American Heart Association/ American Stroke Association, American Physical Therapy Association, American Society of Interventional & Therapeutic Neuroradiology, American Society of Neuroradiology, Association of American Medical Colleges, Boston Scientific, Congress of Neurological Surgeons, Emergency Nurses Association, Johnson & Johnson, National Stroke Association, Society of Interventional Radiology, Stroke Belt Consortium)

MOCK TIMELINE FOR LEGISLATION PROCESS WITH SUGGESTED COMMUNICATION INTERVENTIONS FOR STATES

Failed and pending federal legislation often becomes the model for state legislation. Below is a mock timeline for a state stroke bill that would provide state funding to establish stroke centers and patient care protocols. For many of the milestones for legislation, there are potential communication interventions that can be offered to contribute to the legislature's debate and decision making. All these proposed action items comply with the AR-12 restrictions on lobbying.

Almost all states require that communication activities be coordinated through the health department commissioner's public information office. Before engaging in any of the activities outlined below, staff should be sure to work with the public information/legislative office to receive proper clearances.

Milestone	Potential Communication Intervention	Partner/Type of Communication
Stroke bill simultaneously introduced in State Senate and Assembly	Sponsor a legislative Stroke Prevention day. Consult the Start with Your Heart publication, "Hosting a Legislative Heart Health Day."	American Heart Association/ American Stroke Association
Bills referred to committees on health for both houses	Send committee staff copies of the State burden documents with letters offering background and testimony if desired.	Health department's public information office
American Heart Association conducts annual advocacy day in Statehouse	Give presentation on what state health department is doing to combat stroke.	American Heart Association/ American Stroke Association
Health subcommittee holds hearing on stroke bill	Provide testimony on problem of stroke in state and provide examples of other state successes.	Health department's legislative liaison office
Grassroots letter-writing campaign	Provide background materials to requestor.	State coalition/partners
Considered by subcommittee, mark-up session and forwarded to full committee	Consider working with your health department's legislative office to issue a statement from the director about the legislation.	American Heart Association/American Stroke Association
Full committee holds mark-up session and refers bill for vote by full Assembly	Let local media know that state health department and American Heart Association/American Stroke Association have data and experts who can discuss the state's burden of stroke.	Advocates champion for the legislation from organizations, such as the state chamber of commerce, neurological association, emergency medicine association.

(chart continues on next page)

Milestone	Potential Communication Intervention	Partner/Type of Communication
Vote scheduled by full Assembly		Champion for legislation informs coalition members, communication committee
Bill passed by full Assembly, sent to state Senate for consideration	Issue statement from health department director.	Health department's public information office
Bill referred to conference committee to reconcile difference between Assembly and Senate versions	Encourage partners to provide analysis of differences to conference committee staff.	American Heart Association/ American Stroke Association
Conference bill voted on and approved by both houses	Issue statement from state coalition.	Health department's public information office

CASE STUDIES OF HOW STATE STAFF PARTICIPATED IN STROKE LEGISLATION IN THEIR STATES

Case Study: Primary Stroke Services Regulations in Massachusetts

To help influence policy and environmental change concerning stroke care in Massachusetts, the state program staff developed the Massachusetts Department of Public Health (MDPH) hospital licensure regulations authorizing the Department's Division of Health Care Quality to designate hospitals with primary stroke services. This example provides a model for other state programs to improve quality of care through regulations. The MDPH, nonprofit organizations, providers, and hospitals collaborated to develop these regulations.

The Coordinator of Stroke Initiatives in the Division of Community Health Promotion in the MDPH was the lead cardiovascular health staff person involved with drafting the regulations. Communication with different MDPH internal and external partners was integral to the success of regulation development. The Massachusetts approach to this policy intervention focuses on communication strategies.

Goal	To improve the delivery of stroke care in Massachusetts and have every resident within 30 minutes of designated hospital-based stroke services.
Approach	Partnered with Division of Health Care Quality to draft regulations that create criteria for primary stroke services. Based regulations on Brain Attack Coalition's primary stroke center guidelines, including ■ a stroke service director or coordinator; ■ written care protocols; ■ quality improvement of patient care management; ■ continuing education for health professionals; and ■ community education. Engaged state hospital association to solicit feedback from hospitals and gauge interest in designation. State Heart Disease and Stroke Prevention Program provides technical assistance to help hospitals achieve and maintain designation.
Process	Held open forums to allow hospitals to provide input before drafting regulations. Conducted hospital survey to analyze stroke capabilities and gauge interest in stroke-service designation. Encouraged feedback and testimony during mandatory open comment periods.
Partners	Emergency medical services. State affiliates of the American Heart Association/American Stroke Association. Massachusetts Hospital Association. Massachusetts Council of Community Hospitals.
Challenges	Some hospitals lack understanding about the acute stroke guidelines issued by the Brain Attack Coalition. Concern that designation might impact access to care and cause transfer of patients to hospitals farther from their homes. Concern that some of the requirements might be unattainable without significant investment of resources.
Results	Sixty-five of 72 hospitals have applied for stroke services designation. Groundwork is being built in state for implementing the Paul Coverdell National Acute Stroke Registry.

Case Study: Florida Stroke Act

Florida offers an excellent example for states that may have pending legislation to improve stroke-related policy and regulation. In 2004, Florida passed the Florida Stroke Act (S.B. 1590), which created the nation's first statewide emergency stroke system. The legislation will help ensure that EMS transports stroke victims to a hospital that is capable of providing the latest stroke treatments. In addition, the bill requires the development of criteria for primary and comprehensive stroke centers. The American Heart Association/American Stroke Association (AHA/ASA) helped lead the coalition of groups and organizations that advocated for the successful passage of the act.

Although the Florida Department of Health did not spearhead the creation of S.B. 1590, it was and continues to be critically important to the success of the overall effort. The following summary of an interview with the Florida-Puerto Rico Affiliate of AHA offers some guidance for how states can understand and help advance stroke legislation in their states.

Goal	To strengthen the chain of stroke survival in Florida through legislation establishing statewide stroke systems for EMS services and hospitals to properly identify, transport, and treat stroke victims.
Approach	Identified crucial partners needed to push for a statewide emergency stroke system. Gained support and buy-in from large hospital systems, EMS systems, and state regulatory agencies overseeing health systems in the state. Involved Florida's Agency for Health Care Administration to create criteria for primary and comprehensive stroke centers. Engaged the Florida Department of Health to develop a sample stroke triage assessment tool for all EMS providers. Planned for legislation based on objectives that were laid out by the Florida-Puerto Rico Affiliate of AHA and that were also workable for key stakeholders and regulatory agencies.
Process	Held legislative drafting meetings to which all stakeholders were invited to contribute to the development of the legislation. Planned legislative briefing at the beginning of session to educate legislators and their staff about the bill. Organized lobby day during which nearly 100 volunteers traveled to Tallahassee to meet with legislators and gain the support necessary for the bill's success.
Partners	Florida-Puerto Rico Affiliate of AHA. The Florida Association of EMS Medical Directors. The Florida College of Emergency Physicians. The Florida Hospital Association. Large hospital systems in the state.
Challenges	States had focused most of their stroke activities in the area of prevention and had to evaluate their time and resources to begin the process of developing this new stroke emergency system. Concern that some emergency rooms in sparsely populated areas of the state would not have the resources to adapt to the legislation. Concern that stakeholders and partners would have differing ideas on what to include in the bill. Concern that methods in place might be unable to adapt logistically to a new system.
Results	In 2004, the bill passed and has drastically changed emergency stroke services in the State of Florida. Groundwork is in place for consideration of implementing the Paul Coverdell National Acute Stroke Registry in the state.